

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

51b
0734

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:

Kent
County..... KentCity or town..... Chestertown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... life

Hospital, institution, or street address where death occurred: Washington Ave.

How long in hospital or institution?.....

3. (a) FULL NAME

Thomas Dodd Bowers

4. Sex..... male 5. Color or race..... white 6.(a) Single, married, widowed, or divorced..... married

8. (b) Name of husband or wife..... Marion Lusby Bowers
living

7. Birth date of deceased (mo. day. yr.)..... Nov. 13, 1868

8. AGE: Years..... 79 Months..... 7 Days..... 17 If less than one day..... hrs. min.

9. Birthplace..... Baltimore City, Maryland
(Town, county, and state)

10. Usual occupation..... News Reporter (retired)

11. Industry or business.....

12. Name..... Daniel Bowers

13. Birthplace..... Maryland

14. Maiden name..... Augusta Dodd

15. Birthplace..... Kent Co. Md.

16. Informant..... Mrs. Marion Bowers

Address..... Chestertown, Md.

17. Burial..... Chester Cem.
(Burial, cremation, or removal. Which?)

Cemetery or crematory..... Chester Cem.

Location..... Chestertown, Md.

18. Funeral director..... J. Willis Wells

Address..... Chestertown, Md.

19. Date rec'd by registrar..... July 3, 1948
Date signed.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
Maryland County..... KentCity or town..... Chestertown
(If outside city or town limits, write RURAL and give nearest town)Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

no

MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 1, 1948, at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
5/10/48, 19..., to 7/1/48, 19...

and that I last saw him alive on 7/1/48, 19...

Immediate cause of death..... Cachexia &
uremiaDURATION
2 weeksDue to..... Urinary tract infection
generalized

2 months

Due to..... Squamous cell carcinoma
of prostate gland5 month
duration

Other conditions..... (known)

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

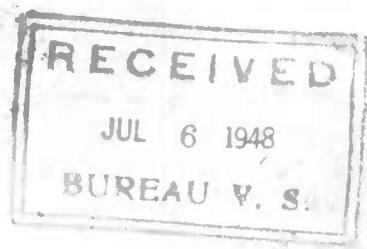
Injured at home, farm, industry, public place (where?)

Means of Injury..... Injured at work?

23. SIGNATURE..... Robert Barnes

M. D. or other

Address..... Chestertown, Md. Date signed..... 7/2/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

946
07350
Reg. Dist. No. 2021

1. PLACE OF DEATH:

County *Kent Co*
 City or town *Still Pond Md.*
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *60 years*

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

*John Williams Clark*4. Sex *Male* 5. Color or race *White* 6.(a) Single, married, widowed, or divorced *Married*6.(b) Name of husband or wife *Mary E. Clark*7. Birth date of deceased (mo.. day, yr.) *1-23-1875* 6.(c) If alive, give age *63* years8. AGE: Years *73* Months *5* Days *18* If less than one day
hrs. min.9. Birthplace *Sasfrass Md*
(Town, county, and state)10. Usual occupation *Clerk*11. Industry or business *Groceries*12. Name *Charles Clark*13. Birthplace *Kent Co Md*14. Maiden name *Anna Matilda Hillburn*15. Birthplace *Kent Co Md*16. Informant *Mary E. Clark*Address *Still Pond Md.*Burial Date thereof *July 14 1948*(Burial, cremation, or removal, Which?) *Still Pond Md*Cemetery or crematory *Still Pond Md*Location *Still Pond Md*18. Funeral director *B. R. Fellows*Address *Still Pond Md*Date rec'd by registrar *July 12 1948*Registrar *Clara S. Barnes*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State *Maryland* County *Kent*

City or town *Still Pond Md*
 (If outside city or town limits, write RURAL and give nearest town)Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (b) Social Security Number

218-12-1255

MEDICAL CERTIFICATION

20. DATE OF DEATH *July 11* 1948 at *4 A.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 10 1948 to *July 11th* 1948and that I last saw him *alive* on *July 11th* 1948

Immediate cause of death

Angina Pectoris DURATION *40 min*

Due to

Due to *acute cold*

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

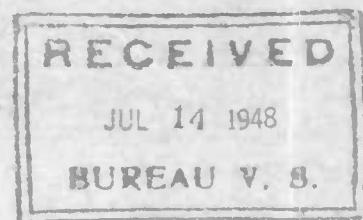
Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE *L. P. Alwell* M. D. or other _____Address *Still Pond* Date signed *7/12/48*

6-41
194X-X-7X
73-3-18

1975-1-23



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

164C

07351

CERTIFICATE OF DEATH

Reg. Dist. No. 203

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color of face

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (a) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof July 7, 1948
(month) (day) (year)

Cemetery or crematory

Wesley Chapel

Location

Rock Hall Md.

18. Funeral director

Edgar L. Lane

Address

Bluff Hill Md

19. Date rec'd by registrar

July 7, 1948

S. Elwood Berger

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

I CERTIFY that death occurred on the date above stated, that I attended deceased from

and that I last saw him/her on

immediate cause of death

DURATION

Honorably Discharged

from Hospital

Infectious Disease

Gunshot Wound

of Chest

Suicide

Other conditions

(Include pregnancy within months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Cause of injury

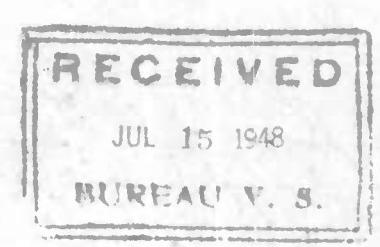
Injured at work?

23. SICKNESS

M. D. or other

Address

Date signed



PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. If the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07352

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:

County

Kent

City or town

Chesertown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

1 year

Hospital, Institution, or street address where death occurred:

305 Cannon St

How long in hospital or institution?

-

3. (a) FULL NAME

Lucie Virginia Conyer

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

fem

col

Married

6. (b) Name of husband or wife

alfred Conyer

6. (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.)

June 24 1893

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Chesertown
(Town, county, and state)

10. Usual occupation

House

11. Industry or business

MOTHER FATHER

12. Name

William Johnson

13. Birthplace

Maryland

14. Maiden name

Emma Rose

15. Birthplace

Maryland

16. Informant

Lucille Warren

Address

305 Cannon St Chesertown

17. Burial

Date thereof July 24-1948
(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or location

Location

18. Funeral director

Address

19. Date record by registrar

Date record by registrar

CERTIFICATE OF DEATH

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Kent

City or town Chesertown
(If outside city or town limits, write RURAL and give nearest town)Street No. 305 Cannon St
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 18 1948 at 2:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

July 4 1948 to July 18 1948

and that I last saw her alive on 7-17 1948

Immediate cause of death

chron ECG - hypertension

Second cause

arteriosclerosis

Hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

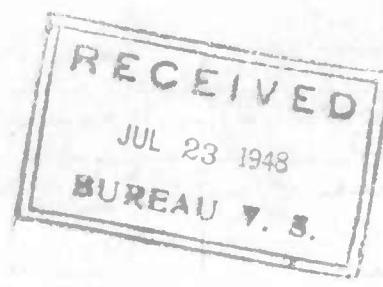
Injured at work?

23. SIGNATURE

Albert A. Burgard M. D. or other

Rock Hall, Md. Date signed 7/20/48

Address



I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07353

CERTIFICATE OF DEATH

Reg. Diat. No. 202

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, months years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

(Date rec'd by registrar)

Clara S. Barnes
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

Jul 10 1948 at 6:07 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

asbestosis, mesothelioma.

DURATION

Pneumonia & bronchitis

Due to

Asbestosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings at operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

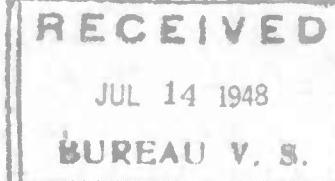
injured at work

Death from mesothelioma

Signature

M. D. or other

Date signed



Evidence for addition of
name and change of age and
birth date shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07354

51 f

FILM NO. G 11. JUL 27 1948 CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:

County.

City or town.

Kent

Chestertown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

8 days

Hospital, institution, or street address where death occurred:

Kent and Queen Annes

How long in hospital or institution?

8 days

3. (a) FULL NAME

Otho Frank Fogwell

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Married

Hallie M Fogwell

6. (b) Name of husband or wife

6. (c) If alive, give age

58 years

7. Birth date of deceased (mo., day, yr.)

October 27, 1881

8. AGE: Years Months Days If less than one day

67 6/6 8 21 hrs. min.

9. Birthplace

Rent County, Maryland

(Town, county, and state)

10. Usual occupation

TANNER

11. Industry or business

Agriculture

MOTHER FATHER

12. Name

Otho and Hallie M. Fogwell

Rock Hall Md.

13. Birthplace

Rock Hall Md.

14. Maiden name

Manda Shaffer

15. Birthplace

Maryland

16. Informant

Mrs. Hallie M. Fogwell

Address

Worton Md Rural

Burial

Date thereof

July 21, 1948

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Chestertown

Location

Chestertown, Md.

18. Funeral director

B.R. Fellows

Address

Still Pond Md

15. Date rec'd by registrar

July 20, 1948

Date rec'd by registrar

Class S. Barnes

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland County

Kent

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

near Worton

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 18

1948

at 8⁴⁵ P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 10

1948

to

July 18 1948

and that I last saw him alive on

July 18

1948

Immediate cause of death

Circulatory collapse

DURATION

Due to Metastatic carcinoma

3 mos?

Due to Carcinoma of prostate

1 year?

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

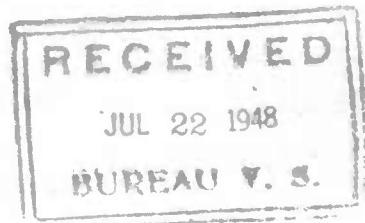
G. A. Dick, M.D.

M. D. or other

Address

Chestertown, Md.

7-18-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of
birth date shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07355

FILM NO. G 116 AUG 10 1948 CERTIFICATE OF DEATH

Reg. Dist. No. 202

61

1. PLACE OF DEATH

County..... Kent -

City or town..... New Market

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... Lifetime

Hospital, Institution, or street address where death occurred:..... no

How long in hospital or institution?..... no

3. (a) FULL NAME

Robert Raymond Hee

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male white married

6.(b) Name of husband or wife

Edwin S. Heptron

7. Birth date of deceased (mo., day, yr.)

November 12 - 1895

6.(c) If alive, give age 71 years

8. AGE:

Years

Months

Days

If less than one day

74

10

12

hrs. min.

9. Birthplace

Fort Henry, Pa

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Dairying

12. Name

Daniel Hee

MOTHER FATHER

13. Birthplace

Pa

MOTHER FATHER

14. Maiden name

Mary J. Kelppatrick

15. Birthplace

Pa

16. Informant

Raymond Hee

Address

New Market, Md

Burial

Date thereof Aug 11 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Still Pond

Location

Still Pond, Md

18. Funeral director

B. W. Fellows

Address

Still Pond, Md.

July 31 1948

(Date rec'd by registrar)

Class S. Barnes, Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Kent -

City or town..... Farm rear New Market

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, same war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 30 1948 at 4 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1948 to July 2 1948

and that I last saw deceased alive on

Immediate cause of death

Diphtheria

Duration 20 years

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Frank W. Smith M. D. & other

Address Bleeding Date signed July 31 1948

RECEIVED
AUG 3 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07356
203

CERTIFICATE OF DEATH

Reg. Diat. No. 202

1. PLACE OF DEATH

County

Rock Hall

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

1 hour

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

None

3. (a) FULL NAME

Louis Lawrence Hoffmann

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife

Caroline Grace Hoffmann

7. Birth date of deceased (mo., day, yr.)

Jan 26, 1890

6. (c) If alive, give age in years

8. AGE:

Years 18 Months 6 Days 14 hrs. min.

9. Birthplace

Newark, NJ

(Town, county and state)

10. Usual occupation

German Train Plant

11. Industry or business

Pabst Brushes

12. Name

Louis Jacob Hoffmann

13. Birthplace

Newark, NJ

14. Maiden name

Louise Schwall

15. Birthplace

Newark, NJ

16. Name

Mrs. Caroline Grace Hoffmann

Address

891 Ray Dr. Union, NJ

17. Burial

Date thereof July 14, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Union Cem.

Location

Union County, New Jersey

18. Funeral director

J. Willis Wells

Address

Chestertown, Maryland

19. Date rec'd by registrar

July 11, 1948

Date reg'd

Clara S. Barnes, Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Mon. Co. Rock Hall

City or town (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

Jul 10, 1948 at 11:45 AM

CERTIFY that death occurred on the date first stated; that I attended deceased from

and that I last saw deceased at 11:45 AM

and that cause of death was

Key records

Coronary

obstruction

Injury

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

None

Date of op.

Autopsy results

No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

No

Date of

Where did injury occur

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Mean of injury

Injured at work

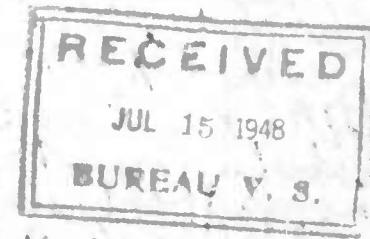
M. D. or other

Cause of death

Address

Date signed

July 10, 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

92e

07357

Reg. Distr. No. 202

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County.....

Kent

City or town.....

Haynesville near St. James

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

April 1948

Hospital, Institution, or street address where death occurred:

House

How long in hospital or institution?.....

3. (a) FULL NAME

Thomas J. Holdson

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

m.

46

widowed

B.(b) Name of husband or wife.....

Etta Holdson

B.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.)

Nov 16 1875

8. AGE:

Years

Months

Days

If less than one day

72

7

14

hrs.

min.

9. Birthplace.....

Haynesville

(Town, county, and state)

10. Usual occupation.....

Farmer

11. Industry or business.....

Retired

12. Name.....

Robert Holdson

13. Birthplace.....

Kent Co. Md

14. Maiden name.....

Elizabeth Sullivan

15. Birthplace.....

Kent Co. Md

16. Informant.....

Mrs. Susie Holdson

Address

Worton, Md.

17. Burial

Date thereof... July 4, 1948

(month) (day) (year)

Cemetery or crematory.....

Union

Location.....

Worton, Kent Co. Maryland

18. Funeral director.....

Marvin V. Williams

Address

Chesapeake, Maryland

19. Date rec'd by registrar.....

July 3, 1948

Clara S. Barnes

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Kent

City or town..... Haynesville

(If outside city or town limits, write RURAL and give nearest town)

Street No..... near St. James church

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH.....

July 1

19

48 at 11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Beginning April 1948 to July 1, 1948

and that I last saw him alive on June 2, 1948

Immediate cause of death.....

chronic colitis or ulceris

decomposition

Due to.....

angina pectoris

coronary sclerosis

Due to.....

arthritis

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

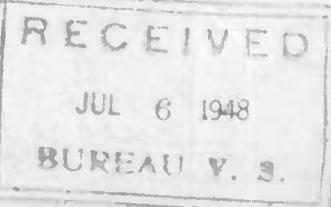
Injured at work?.....

23. SIGNATURE.....

Albert A. Burgard
Rock Hall, Md.

M. D. or other

Date signed..... 7/1/78



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07358

CERTIFICATE OF DEATH

183
Reg. Date No. 2021

1. PLACE OF DEATH:
 County Chesapeake
 City or town Chesapeake
(If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 or 4 days
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Kent
 City or town Chesapeake
(If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (b) Social Security Number _____

3. (a) FULL NAME Paul Edward Johnson4. Sex Male 5. Color or race Cop 6. (a) Single, married, widowed, or divorced Don't know6. (b) Name of husband or wife Don't know7. Birth date of deceased (mo., day, year) Sept 14 1921 8. (c) If alive, give age years8. AGE: 26 Years 9 Months 28 Days If less than one day hrs. min.9. Birthplace Cambridge Md (Town, county, and state)10. Usual occupation La borer11. Industry or business Fruit & Vegetable12. Name Don't know13. Birthplace Don't know14. Maiden name Selmae15. Birthplace Cambridge Md16. Informant my selfAddress Park Hall Rd17. Burial Burial Date thereof July 14 1948
(Burial, cremation, or removal. Which?)Cemetery or crematory Silent City CemeteryLocation Cambridge - Dorchester Co. Md.18. Funeral director Lewis H. PayneumAddress Cambridge, Maryland19. Date rec'd by registrar July 13 1948 Clara S. Barnes
VS A15

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11 1948, et21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Did not attend Don't know and that I last saw alive in Don't know Immediate cause of death as result of bad exam.Due to Swimming Don't know

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. _____Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of July 11 1948Where did injury occur? Chesapeake (City or town) Chesapeake (County) Md (State)Injured at home, farm, industry, public place (where?) NoneMeans of Injury Drowned Injured at work? NoneCause of death Bad exam. Date of death July 11 1948Signature Clara S. Barnes M. D. or other _____Address Chesapeake Md Date signed July 13 1948

RECEIVED
JUL 15 1948
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07359

202

Reg. Dist. No. 22a

1. PLACE OF DEATH:

County Kent
 City or town Still Pond Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, institution, or street address where death occurred: _____

How long in hospital or institution? _____

3. (a) FULL NAME

Herbert Jones

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Males | C Married
Malinda Jones

6.(b) Name of husband or wife

6.(c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.)

June 30 - 1881

8. AGE:

Years 67Months - 27

Days

If less than one day

hrs. min.

9. Birthplace

Kent Co Md.

(Town, county, and state)

10. Usual occupation

Labor

11. Industry or business

Farm work

MOTHER FATHER

12. Name

John Jones

13. Birthplace

Maryland

14. Maiden name

Mary Miller

15. Birthplace

Maryland

16. Informant

Reba Lillian Johnson

Address

Still Pond Md.

17. Burial

Date thereof July 30 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Rural Cemetery Boston Md.

Cemetery or crematory

Morton Md Rural

Location

B R Fellows

18. Funeral director

Still Pond Md.

Address

Still Pond Md.

19. Date rec'd by registrar

Clara S. Barnes

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County KentCity or town Still Pond Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1948at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 26 to July 27, 1948and that I last saw him alive on July 27.

Immediate cause of death

Pneumonia
Atrial fibrillation

DURATION

1 yr

Due to

Due to

Other conditions

Scotial Hemia

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

L. P. Alvest

M. D. or other

Address Still Pond Date signed 7/28/48

RECEIVED

AUG 2 1948

BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07360

CERTIFICATE OF DEATH

Reg. Dist. No. 203

I. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *1 day*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Thomas Indefinid

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

*m.**wh.**single*

B. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age _____ years

Sept 22 1872

8. AGE:

Years

Months

Days

If less than one day

*75**9**20*

hrs.

min.

9. Birthplace.....

Washington D. C.

(Town, county, and state)

10. Usual occupation.....

*Carpenter**retired*

11. Industry or business

MOTHER / FATHER

12. Name.....

John W. Indefinid

13. Birthplace

Maryland

14. Maiden name.....

Parale F. Braff

15. Birthplace

Maryland, Kent Co.

16. Informant.....

Charles Tyson

Address

Rock Hall, Md.

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof *July 14, 48*
(month) (day) (year)

Cemetery or crematory

Location

*Wesley Chapel**Rock Hall, Md.*

18. Funeral director.....

Address

*Edgar L. Lane**Chaptown*

19. Date rec'd by registrar

19.48

(Date rec'd by registrar)

S. Elwood Burgard

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland*County *Kent*City or town *Rock Hall*

(If outside city or town limits, write RURAL and give nearest town)

Street No. *Haven*

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 12 1948 at 5:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7/8 1948 to 7/12 1948

and that I last saw h. in alive on

7/12 1948

Immediate cause of death.....

*From Endo - Myocarditis
Decompressions*

Due to.....

arterio sclerosis

Due to.....

Hypertension

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

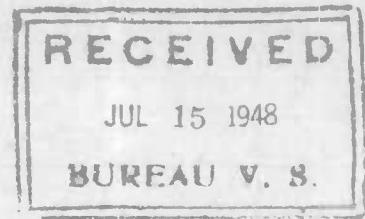
Means of injury

Injured at work?

23. SIGNATURE *Auer & A. Burgard*

M. D. or other

Address *Rock Hall, Md.*Date signed *7/13/48*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The content page is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07361

CERTIFICATE OF DEATH

93d
Reg. Dist. No. 202

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof July 23-1948
(month) (day) (year)

Cemetery or crematory

Pending

Location

Baltimore, Md.

18. Funeral director

Address

19. Date read by registrar

July 26, 1948

Date read by registrar

Class L. Barnes

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jul 20 1948 at M
I CERTIFY that death occurred on the date above stated; that I attended deceased from
and that I last saw him/her at the time of death
Immediate cause of death as per physician's certificate
frobbing obstruction

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. GUNSHOT

Hand gun in hand
Death was due to
the shot from a gun
M. D. of other
Address Date signed

July 26, 1948

RECEIVED

JUL 22 1948

BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95C

07362

200

Reg. Dlat. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County.....

City or town.....

Baltimore Wilmington
Delaware 6 Days

How long in above place of death?

Hospital, institution, or street address where death occurred.

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female Colored Widowed

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo. day, yr.)

8. (c) If alive, give age..... years

March 21 1892

8. AGE:

Years

Months

Days

If less than one day

56

hrs. min.

9. Birthplace.....

Delaware

(Town, county, and state)

10. Usual occupation.....

Housework

11. Industry or business

MOTHER FATHER

12. Name..... unknown

13. Birthplace..... unknown

14. Maiden name..... unknown

15. Birthplace..... unknown

16. Informant.....

Charly H. Priest (son)

Address

Wilmington Del

17. Burial

Date thereof.....

Aug. 4, 1948

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director.....

Address

July 30
(Date rec'd by registrar)

Mt. Zion

Wilmington Del.

Edward Fellow

Wilmington Md

Edward Fellow

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

Wilmingtton

Street No.....

New Castle

2.(a) If veteran, name war.....

(If rural, give LOCATION)

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

2D. DATE OF DEATH

July 30 1948 at 9²⁰ A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 29 1948 to July 30 1948

and that I last saw her alive on July 29 1948

Immediate cause of death.....

Acute dilatation of Heart

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

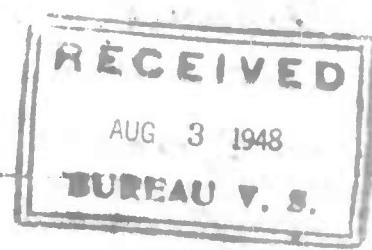
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE..... H.H. Hamilton

Address..... Wilmington Ma Date signed July 30 1948



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46b
07363

Reg. Dist. No. 2021

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

Kent

Chesterstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital Institution, or street address where death occurred:

Kent & Queen Anne General

How long in hospital or institution?

25 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland County Kent

City or town

Kennedyville

Street No.

(If outside city or town limits, write RURAL and give nearest town)

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

3. (a) FULL NAME

Joseph Lindle Rhoades

4. Sex

5. Color of face

6. (a) Single, married, widowed, or divorced

Male

White

married

6. (b) Name of husband or wife

Sicie C. D. Rhoades

7. Birth date of deceased (mo., day, yr.)

March 16, 1869

6. (c) If alive, give age.....years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Chesapeake City Cecil Maryland

(Town, County, and state)

10. Usual occupation

Retired merchant

11. Industry or business

MOTHER FATHER

12. Name

Williams H. Rhoades

13. Birthplace

Maryland

14. Maiden name

Martha Bryly

15. Birthplace

Maryland

16. Informant

Mrs. Joseph L. Rhoades

Address

Kennedyville, Md.

17. Burial

Date thereof

(month) (day) (year)

(Burial, cremation, or removal, Which?)

Cemetery or cremator

Location

Forest cemetery

Middletown Del.

18. Funeral director

J. Lester Davis

Address

Middletown Del.

19. July 14 1948

Date read by registrar

Clara S. Barnes

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 12 1948 at 9:55 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

EST. 5-15 1948 to 7-12 1948

and that I last saw him alive on

7-12 1948

Immediate cause of death

Carcinoma of stomach

Unknown

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Robert W. Farr M. D. mother

Address Chesterstown, Md. Date signed July 13 1948

RECEIVED
JUL 16 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07364
203

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County.....

Kent

City or town.....

Rock Hall

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

1 hr

Hospital, Institution, or street address where death occurred:

Frederick Rd.

How long in hospital or institution?.....

3. (a) FULL NAME

George Tilceen Erie

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M.

F.

married

6. (b) Name of husband or wife.....

Bessie Erie

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

70 years

Aug 22 1877

8. AGE: Years

Months

Days

If less than one day

70

4

10

7

hrs. min.

9. Birthplace.....

Rock Hall, Md.

(Town, county, and state)

10. Usual occupation.....

Dorekeeper

11. Industry or business

Self

MOTHER FATHER

12. Name

William Erie

13. Birthplace

Rock Hall, Md

14. Maiden name

Elizabeth Joiner

15. Birthplace

Rock Hall

16. Informant.....

Mrs. Bessie Erie

Address

Rock Hall, Md.

17. Burial

Date thereof.....

July 15 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Worley Chapel

Location

Rock Hall, Md.

18. Funeral director

E. L. Evans

Address

Church St., Md.

19. (Date read by registrar)

July 31 - 1948 S. Elwood Burgess

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland

County.....

Kent

City or town.....

Rock Hall

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

Frederick Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

July 29

1948 2 P.M.

21 I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/29/48 2 P.M. 1948 to 7/29/48 3:05 P.M.

and that I last saw h. alive on 7/29/48

19

Immediate cause of death

cerebral hemorrhage

hypertension

DURATION

Due to endotracheitis (drown)

Due to subarachnoid hemorrhage

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

7

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

1

1

1

Means of injury

Injured at work?

1

23. SIGNATURE

Albert H. Burgess

M. D. *smashed*

Rock Hall, Md.

Date signed 7/29/48

Address

RECEIVED

AUG 9 1948

BUREAU U. S.

I

The correct size

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct size

is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07365

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 200

1. PLACE OF DEATH:

County

City or town

Kent

Millington

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

30 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Bessie Jane Wallace

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Married

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

April 16 1882

8. AGE:

Years
66

Months

Days

If less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

Delaware

10. Usual occupation

Housewife

11. Industry or business

Frank R. Murphy

MOTHER FATHER

12. Name

Isabell

Mashin

13. Birthplace

Delaware

14. Maiden name

Isabell

Mashin

15. Birthplace

Md.

16. Informant

Mrs John O'Neal

Address

Rural Millington Md.

17. Burial

Date thereof July 11 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

(Cemetery or crematory)

Blackinton Churchyard

Location

Near Clayton Del.

18. Funeral director

Edward Fellow

Address

Millington Md.

19. Date rec'd by registrar

July 9 1948 Edward Fellow

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

City or town

Rural

County

Street No.

Millington

Street

2.(a) If veteran, name war

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 7 1948 at 6:13 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 28 1948 to July 7 1948

and that I last saw her alive on July 6 1948

Immediate cause of death Cardiac Decompen-

sation.

DURATION

Due to Arteriovenous Heart Disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Meane of Injury

Injured at work?

23. SIGNATURE

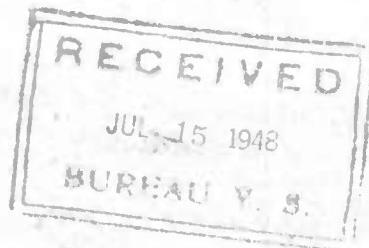
H H Hamilton

M. D. or other

Address

Millington

Date signed July 9 1948



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50

07366

CERTIFICATE OF DEATH

Reg. Dist. No. 204

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

left home

Hospital, Institution, or street address where death occurred:

no

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female Col married

6. (b) Name of husband or wife

Wellesley Bradley

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

59 years

8. AGE:

Years Months Days If less than one day
60 6 14 hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

Joseph Jelighard

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

17. Burial, cremation, or removal. Which?

18. Funeral director

19. Date rec'd by registrar

Date thereof

(month)

(day)

(year)

Comotory or crematory

Location

Means of injury

23. SIGNATURE

Address

Date signed

Date rec'd by registrar

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 5 1948 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that attended deceased from

July 4 1948 to July 4 1948

and that last saw her alive on July 4 1948

Immediate cause of death

Secondary disease

Cause of Death

Due to

Metastatic carci-

Due to

Brain

Other conditions

Brain

(Include pregnancy within 3 months of death)

Major findings of operation

Cure of Brain -

removed

Date of op. 1948

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Fraud Whitt

Address

Date signed

Debuton

M. D. other

